The Coalition for Improving Maternity Services: Evidence Basis for the Ten Steps of Mother-Friendly Care

Barbara A. Hotelling, MSN, CD (DONA), LCCE, FACCE

ABSTRACT

One factor explaining why women choose unnecessary high-tech births is their lack of knowledge of the research. Presenting research in Lamaze class can be difficult; however, teaching tools described in this article may help facilitate evidence-based discussions. The recently published *Journal of Perinatal Education* supplement issue written by the Coalition for Improving Maternity Services Expert Work Group gives Lamaze educators a rich resource to pass along to expectant parents.

Journal of Perinatal Education, *16*(2), 38–43, doi: 10.1624/105812407X197744

Keywords: The Coalition for Improving Maternity Services, Mother-Friendly Childbirth Initiative, Ten Steps of Mother-Friendly Care, normal birth, childbirth education

For a copy of the CIMS Mother-Friendly Childbirth Initiative *and accompanying* Ten Steps of Mother-Friendly Care, *call CIMS toll-free at 888-282-2467 or log on to the organization's Web site (www.motherfriendly.org).*

Members of the CIMS Expert Work Group were:

- *Henci Goer, BA, Project Director*
- *Mayri Sagady Leslie, MSN, CNM*
- *Judith Lothian, PhD, RN, LCCE, FACCE*
- *Amy Romano, MSN, CNM*
- *Karen Salt, CCE, MA*
- *Katherine Shealy, MPH, IBCLC, RLC*
- *Sharon Storton, MA, CCHT, LMFT*
- *Deborah Woolley, PhD, CNM, LCCE*

In 1996, the Coalition for Improving Maternity Services (CIMS) launched its landmark consensus document, *The Mother-Friendly Childbirth Initiative* (CIMS, 1996a) and the accompanying *Ten Steps of the Mother-Friendly Childbirth Initiative for Mother-Friendly Hospitals, Birth Centers, and Home Birth Services* (CIMS, 1996b). The document was the culmination of 2 years' worth of birth organizations and stakeholders meeting to foster collaboration in a national effort to support, protect, and promote normal birth and breastfeeding (Lothian, 2007). Before 1996, little collaboration existed among birth organizations. Yet, they eventually came together for a greater good and, using a consensus model of decision-making, they agreed upon 10 evidence-based steps that promote a wellness model of maternity care to improve birth outcomes and substantially reduce health-care costs (CIMS, 1996b).

Fast-forward to 2005, when CIMS designated an expert work group to examine the current research that substantiates the *Ten Steps of Mother-Friendly Care*. Members of the CIMS Expert Work Group came from a variety of professional backgrounds and were knowledgeable about research and mother-friendly care. Their findings were published in a supplement to *The Journal of Perinatal Education* (JPE) issue released at the end of February (CIMS, 2007).

Although research literature in general may often daunt the typical childbirth educator, the evidence introduced in the supplement issue is presented in a concise, scholarly manner and provides an excellent, evidence-based overview of the *Ten Steps*. Referred to as "the CIMS supplement," the special JPE publication (CIMS, 2007) can be used in childbirth education classes to raise the

BOX 1

The Coalition for Improving Maternity Services (CIMS): Philosophical Cornerstones of *The Mother-Friendly Childbirth Initiative*

Teaching tools: *The Mother-Friendly Childbirth Initiative* (CIMS, 1996a) and *Evidence Basis for the Ten Steps of Mother-Friendly Care* (CIMS, 2007).*

Teaching suggestion: Print each of the five philosophical cornerstones on a separate piece of paper or card. Distribute to class members for small-group discussion. After an appropriate time, gather the class together again for summaries of their group discussions.

Note: When copying and sharing this information with your class, please keep the wording intact and credit the appropriate source.

1. Normalcy of the Birthing Process

Birth is a normal, natural, healthy process, and women and babies have the inherent wisdom necessary for birth. Babies are aware, sensitive human beings at birth. Breastfeeding provides optimum nourishment for newborns and infants. Birth can safely take place in hospitals, birth centers, and homes. The midwifery model of care, supporting and protecting the normal process of birth, is the most appropriate care for most women during pregnancy and birth (CIMS, 1996a, 2007).

2. Empowerment

A woman's confidence and ability to give birth and care for her baby are enhanced or diminished by every person who gives her care and by the environment in which she gives birth. A mother and baby are distinct, yet interdependent, during pregnancy, birth, and infancy. Their interconnectedness is vital and must be respected. Pregnancy, birth, and the postpartum period are milestone events in the continuum of life. These experiences profoundly affect women, babies, fathers, and families and have important and long-lasting effects on society (CIMS, 1996a, 2007).

3. Autonomy

Every woman should have the opportunity to have a healthy and joyous birth experience and to give birth as she wishes in an environment in which she feels nurtured and secure, and in which her emotional well-being, privacy, and personal preferences are respected. She should have access to the full range of options for pregnancy, birth, and nurturing her baby; receive accurate and up-to-date information about the benefits and risks of all procedures, drugs, and tests; and be allowed the rights of informed consent and informed refusal. Finally, she should receive support for making informed choices about what is best for her and her baby based on her individual values and beliefs (CIMS, 1996a, 2007).

4. Do No Harm

Interventions should not be applied routinely during pregnancy, birth, or the postpartum period. If complications arise, medical treatments should be based on the latest high-quality evidence (CIMS, 1996a, 2007).

5. Responsibility

Each caregiver is responsible for the quality of care she or he provides. Maternity care practices should be based not on the needs of the caregiver or provider, but solely on the needs of the mother and child. Each hospital and birth center is responsible for the periodic review and evaluation, according to current scientific evidence, of the effectiveness, risks, and rates of use of its medical procedures. Society, through both its government and the public health establishment, is responsible for ensuring access to maternity services for all women and for monitoring the quality of those services. Individuals are ultimately responsible for making informed choices about the health care they and their babies receive (CIMS, 1996a, 2007).

*Sources

Coalition for Improving Maternity Services. (1996a). *The mother-friendly childbirth initiative.* Retrieved February 1, 2007, from http://www.motherfriendly.org/MFCI/

Coalition for Improving Maternity Services, Expert Work Group. (2007). Evidence basis for the ten steps of mother-friendly care [Entire issue]. *Journal of Perinatal Education, 16*(Suppl. 1).

awareness of expectant parents so they can make informed decisions about their health care. Although we are not all wired to evaluate the validity of research, we are thankful for those who are. In this case, the CIMS Expert Work Group provides childbirth educators with a magnificent gift to pass along to expectant women and their families. In this "Tools for Teaching" column, I offer some teaching suggestions for presenting the research summarized in the CIMS supplement.

BASIC CONCEPTS FOR EXPECTANT PARENTS

The CIMS (2007) supplement provides educators with several concepts parents should understand when making decisions about their health care. First, birth is not an illness waiting to happen. Birth is profoundly physiologic, and medical interventions were developed for the few occasions when birth became pathologic and required assistance. Like many other new trends, birth technology has gotten out of control. Although cesareans were

BOX 2

The Coalition for Improving Maternity Services (CIMS): *The Ten Steps of Mother-Friendly Care*

Teaching tools: *The Ten Steps of the Mother-Friendly Childbirth Initiative for Mother-Friendly Hospitals, Birth Centers, and Home Birth Services* (CIMS, 1996b) and *Evidence Basis for the Ten Steps of Mother-Friendly Care* (CIMS, 2007).*

Teaching suggestion: Copy and distribute this handout (but without the ''X'' marks) to class participants. Ask them to identify who is responsible for helping them gain access to each step and, then, discuss their responsibilities in achieving the birth they desire.

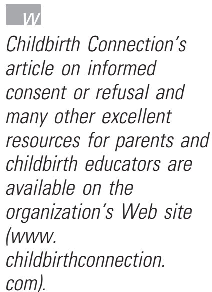
Note: When copying and sharing this information with your class, please keep the wording intact and credit the appropriate source.

STEP	MOTHER	FATHER	DOULA	MIDWIFE	DOCTOR	PLACE OF BIRTH	NURSE
1. Unrestricted access to birth companions, labor support, and professional midwifery care.					X	X	X
2. Accurate, descriptive, statistical information about birth care practices.				X	X	X	X
3. Culturally competent care.			X	X	X	X	X
4. Freedom of movement to walk, move, and assume positions of the mother's choice.	X	X		X	X	X	X
5. Clearly defined policies, procedures for collaboration, consultation, and links to community resources.			X	X	X	X	X
6. Does not routinely employ practices and procedures, unsupported by scientific evidence.			X	X	X	X	X
7. Educates staff in nondrug methods of pain relief and does not promote use of unrequired analgesic or anesthetic drugs.						X	
8. Encourages all mothers and families to touch, hold, breastfeed, and care for their babies.	X	X		X	X	X	X
9. Discourages nonreligious circumcision of the newborn.	X	X		X	X	X	X
10. Strives to achieve the WHO/UNICEF *Ten Steps of the Baby-Friendly Hospital Initiative* to promote successful breastfeeding.			X	X	X	X	X

*Sources:

Coalition for Improving Maternity Services. (1996b). *Ten steps of the mother-friendly childbirth initiative for mother-friendly hospitals, birth centers, and home birth services*. Retrieved March 25, 2007, from http://www.motherfriendly.org/MFCI/steps.html

Coalition for Improving Maternity Services, Expert Work Group. (2007). Evidence basis for the ten steps of mother-friendly care [Entire issue]. *Journal of Perinatal Education, 16*(Suppl. 1).



Childbirth Connection's article on informed consent or refusal and many other excellent resources for parents and childbirth educators are available on the organization's Web site (www.childbirthconnection.com).

once life-saving interventions, they are now touted by the medical community as preferable to vaginal birth. Research does not support this point of view, and educators should know and disseminate the evidence, concluding whether the benefits of the intervention outweigh the harm. Yes, ''harm,'' not ''risk''—a distinction that leads me to the second concept parents should know: ''[T]he excessive use of intervention is, in itself, harmful because it imposes risks with no evidence of benefit'' (Goer, 2007, p. 6S). Too many women choose cesarean birth because of fear, lack of information, and improper guidance by their care providers. When the mother's or infant's condition requires surgical intervention, the procedure is a blessing. However, cesarean birth carries with it the potential for harm to the mother and baby and increased risk in future pregnancies. Balanced against life or death, the harms are acceptable. Yet, how acceptable are they when the mother simply wants to ''get the birth over with''?

The third concept educators should discuss in childbirth classes is informed consent and informed refusal. Most providers are knowledgeable about informed consent, but too few know their responsibilities when the mothers are informed and refuse interventions. Childbirth Connection (2006) provides powerful information on this topic in its online article, ''Informed Decision Making, Informed Consent or Refusal,'' which you can download and share with the parents in your classes.

PHILOSOPHICAL CORNERSTONES

The CIMS *Mother-Friendly Childbirth Initiative* (1996a) identifies five philosophical cornerstones of mother-friendly care, which are also described in the introduction to the CIMS supplement (CIMS, 2007). Print a description of each of the five cornerstones (see Box 1) on a separate piece of paper or card and distribute the paper or card to your class participants. This will place mothers and fathers or support people in different discussion groups. Ask them to discuss how the cornerstone principle may affect their pregnancy, birth, and postpartum period. Identify reporters for each group and, after an appropriate time, bring the class back together for summaries of their discussions.

IDENTIFYING RESPONSIBILITY FOR RECEIVING MOTHER-FRIENDLY CARE

Each of the 10 steps identified as benchmarks for hospitals, birth centers, or home birth practices to provide mother-friendly care is supported by evidence-based research, as presented in the CIMS supplement (CIMS, 2007). You can introduce your class participants to the steps and generate pertinent discussion by giving them the handout (but without the "X" marks) displayed in Box 2. Ask them to decide whose responsibility it is to help families gain access to each of the 10 steps and, then, discuss the parents' responsibilities in having the type of birth they desire.

FACT VERSUS OPINION

Simple props can be constructed to provide ongoing emphasis on the evidence-based information presented in your classes. At the very beginning, discuss with class participants the decision for CIMS to provide research evidence for the *Ten Steps of Mother-Friendly Care* (CIMS, 1996b) and to publish the findings in the JPE supplement (CIMS, 2007). Because we often do not have all the evidence we need, we sometimes state educated opinions. Educated opinions may be based on personal experiences or information we get from our networks. Mother and babies are not appropriate subjects for all research because of safety risks and potential harm. We are certainly able to use our educated opinions as long as we identify them as such and do not confuse them with research. As depicted in the accompanying Figure, use an opinion/fact paddle or a hat to illustrate "fact" or "opinion" sources throughout your class discussions.

Figure Props such as a paddle or cap with "fact" and "opinion" written on opposing sides can help illustrate your presentation of information that is based on research evidence or educated opinions.

DISCUSSING THE LIKELIHOOD OF ROUTINE INTERVENTIONS

Step 6 of the *Ten Steps of Mother-Friendly Care* (CIMS, 1996b) addresses the use and rates of birth interventions. Not all birth interventions are contained in Step 6. The authors included only those interventions for which there was strong evidence.

The section on Step 6 presented in the CIMS supplement (CIMS, 2007) offers an excellent overview of the evidence related to these practices and procedures. You can share a more concise view with your class members by copying and distributing the handout illustrated in Box 3. Encourage parents to ask their care providers about their own rates of intervention. In a subsequent class, parents can present their findings and compare intervention rates among a variety of providers.

ADDITIONAL RESOURCES

For Parents

In addition to the resources described above, another excellent tool for expectant parents is the CIMS (2000) document *Having a Baby? Ten Questions to Ask*, which is available on the CIMS Web site (www.motherfriendly.org). Many parents tour their intended birth facilities during the last trimester of pregnancy. Encourage them to download the CIMS questions, or distribute copies to them, so they can evaluate the kind of care they will receive in their chosen facility.

BOX 3

The Coalition for Improving Maternity Services (CIMS): Step 6 of *The Ten Steps of Mother-Friendly Care*

Teaching tools: *The Ten Steps of the Mother-Friendly Childbirth Initiative for Mother-Friendly Hospitals, Birth Centers, and Home Birth Services* (CIMS, 1996b) and *Evidence Basis for the Ten Steps of Mother-Friendly Care* (CIMS, 2007).*

Teaching suggestion: Copy and distribute this handout to class participants. Encourage parents to ask their care providers about their rates of intervention. In a subsequent class, parents can present their findings and compare intervention rates among a variety of providers.

Note: When copying and sharing this information with your class, please keep the wording intact and credit the appropriate source.

Routine Interventions	Evidence	Reality
	Based on the following sources: Enkin, M., Keirse, M., Neilson, J., Crowther, C., Duley, L., Hodnett, E., et al. (2000). *A guide to effective care in pregnancy and childbirth* (3rd ed.). New York: Oxford University Press. Coalition for Improving Maternity Services [CIMS], Expert Work Group. (2007). Evidence basis for the ten steps of mother-friendly care [Entire issue]. *Journal of Perinatal Education, 16* (Suppl. 1).	Based on the following source: Declercq, E., Sakala, C., Corry, M., & Applebaum, S. (2006). *Listening to mothers II: Report of the second national U.S. survey of women's childbearing experiences*. New York: Childbirth Connection.
Shaving	Ineffectiveness or harm demonstrated by clear evidence (Enkin et al., 2000) No evidence of benefit (CIMS, 2007).	3%
Enemas	Ineffectiveness or harm demonstrated by clear evidence (Enkin et al., 2000). No evidence of benefit (CIMS, 2007).	7%
Intravenous drips	Forms of care unlikely to be beneficial (Enkin et al., 2000). No evidence of benefit (CIMS, 2007).	80%, or 4 out of 5 mothers
Withholding food and fluids	Forms of care unlikely to be beneficial (Enkin et al., 2000). No evidence of benefit (CIMS, 2007).	Only 15% reported eating anything in labor; only 40% said they had anything to drink.
Early rupture of membranes	To release amniotic fluid after labor has begun: Forms of care of unknown effectiveness (Enkin et al., 2000). No evidence of benefit (CIMS, 2007).	59%, or 6 out of 10 mothers
Continuous electronic fetal monitoring (EFM)	Without access to fetal scalp sampling during labor: Ineffectiveness or harm demonstrated by clear evidence (Enkin et al., 2000). Harm established; only benefit is a reduction in neonatal seizure in institutions using high-dose oxytocin protocols (CIMS, 2007).	94% had EFM; 93% of those mothers were monitored continuously
Elective induction	Induction of labor for prelabor rupture of the membranes at birth. Induction instead of surveillance for pregnancy after 41 weeks gestation. Forms of care with a trade-off between beneficial and adverse effects (Enkin et al., 2000). A 10% rate can be achieved without compromising outcomes (CIMS, 2007).	41% of women reported their caregiver tried to induce labor; 84% of the time, it was successful. 55% had synthetic oxytocin to strengthen or speed up contractions after labor had begun.
Episiotomy	Forms of care likely to be ineffective or harmful (Enkin et al., 2000). A 1% rate can be achieved without compromising outcomes (CIMS, 2007).	25%, or 1 in 4 mothers.
Cesarean rate	The optimal rate is not known, but from national data available, little improvement in outcome appears to occur when rates rise above about 7% (Enkin et al., 2000). A 12% rate can be achieved without compromising outcomes (CIMS, 2007).	33%, or 1 out of 3 mothers. Half were primary or first-time cesareans; half were repeat surgeries. Most repeat cesareans were planned.
Vaginal Birth After Cesarean (VBAC) rate	Forms of care that are likely to be beneficial (Enkin et al., 2000). 3 out of 4 women or more who plan VBAC should have a vaginal birth; risks escalate with multiple repeat cesareans (CIMS, 2007).	45% of the mothers with previous cesarean births were interested in VBAC; 57% of them were denied that option.

*Sources:

Coalition for Improving Maternity Services. (1996b). *Ten steps of the mother-friendly childbirth initiative for mother-friendly hospitals, birth centers, and home birth services*. Retrieved March 25, 2007, from http://www.motherfriendly.org/MFCI/steps.html

Coalition for Improving Maternity Services, Expert Work Group. (2007). Evidence basis for the ten steps of mother-friendly care [Entire issue]. *Journal of Perinatal Education, 16*(Suppl. 1).

For Educators

Sometimes, Lamaze educators feel isolated from the real world because normal, physiologic birth is referred to as "alternative birth" and is as difficult to achieve as establishing Lamaze classes was in the 1960s. During the past decade, there has been a rise in awareness and growth of grassroots, consumer-education groups called "birth networks." When Lamaze first started identifying and publicizing existing birth networks, 14 existed in the United States. Today, the Lamaze Institute for Normal Birth Web site lists 54 birth networks. The number continues to grow, month by month.

Both you and your class participants will benefit from the support, information, and community resources provided by these networks. If you don't have a birth network in your community, you can access valuable information on how to start one by calling Lamaze International (800-368-4404) or visiting the Lamaze Institute for Normal Birth link on the Lamaze Web site (www.lamaze.org).

REFERENCES

Childbirth Connection. (2006). *Vision, mission & beliefs—Informed decision making, informed consent or refusal.* Retrieved March 25, 2007, from http://www.childbirthconnection.org/article.asp?ck=10081

Coalition for Improving Maternity Services. (1996a). *The mother-friendly childbirth initiative.* Retrieved March 26, 2007, from http://www.motherfriendly.org/MFCI/

Coalition for Improving Maternity Services. (1996b). *Ten steps of the mother-friendly childbirth initiative for mother-friendly hospitals, birth centers, and home birth services.* Retrieved March 25, 2007, from http://www.motherfriendly.org/MFCI/steps.html

Coalition for Improving Maternity Services. (2000). *Having a baby? Ten questions to ask.* Retrieved March 26, 2007, from http://www.motherfriendly.org/resources/10Q/

Coalition for Improving Maternity Services, Expert Work Group. (2007). Evidence basis for the ten steps of mother-friendly care [Entire issue]. *Journal of Perinatal Education, 16*(Suppl. 1).

Goer, H. (2007). The Coalition for Improving Maternity Services: Evidence basis for the ten steps of mother-friendly care—Methods. *Journal of Perinatal Education, 16*(Suppl. 1), 5S–9S.

Lothian, J. A. (2007). The Coalition for Improving Maternity Services: Evidence basis for the ten steps of mother-friendly care—Introduction. *Journal of Perinatal Education, 16*(Suppl. 1), 1S–4S.

BARBARA HOTELLING *is an independent childbirth educator and doula in Rochester Hills, Michigan. She has served as president of Lamaze International, president of Doulas of North America (DONA), and chair of the Coalition for Improving Maternity Services (CIMS).*

RECERTIFY TODAY AND MAINTAIN YOUR LAMAZE CREDENTIAL

As a Lamaze Certified Childbirth Educator (LCCE), you demonstrate to maternal-child health professionals and expectant families that you have met a standard level of knowledge and skill – that you are a competent childbirth educator.

To promote continued competence through life-long learning, an LCCE educator must recertify *every three years*.

The next recertification deadline is June 30, 2007.

To print the recertification application and to learn more about recertification requirements, visit ***www.lamaze.org***.